Policy No.:
Claim No.:

Tata AIA Life Insurance Company Limited

(hereinafter called "Tata AIA" or "the Company", whichever is applicable)

HOSPITALIZATION CLAIM FORM

Office _____
Agency _____ Code _____
Agent _____ Code _____

PART I (To be completed by Insured/Claimant in BLOCK letters)
Please answer all questions, use "not applicable" (N/A) as appropriate instead of leaving it blank. Counter-sign where amendments/alterations are made in the form.
The filing of this claim form is not to be construed as an admission of liabilities of our Company. No agent has been or is authorized to admit any liabilities on behalf of the Company.
(Note: - Insured's name should be written in full as the same will appear on the cheque)

Policy No.	Full Name of Insured Alias, if any	Age Sex
Benefits to Claim: (please tick) ☐ Daily Hospital Benefit ☐ Post-Hospitalization Benefit ☐ Surgical Benefit ☐ Dismemberment		
Insured's Address Contact Phone No. **Bank Account No.**		I. D. No. I. D. Document Type
Occupation & exact duties	Employer Name & Address Contact Phone No.	
Are you claiming from other insurers or institutions (including government/welfare schemes) for the same cause? ☐ Yes, for (type & amount) _____ from _____ ☐ No _____ from _____		
Did a medical leave certificate filed to Insured's employer? ☐ Yes, (state the dates) _____ ☐ No		

Claims Details

Describe initial symptoms / parts of body injured	Since when does the Insured have these symptoms / bodily injury MM DD YYYY Date of first consultation MM DD YYYY
Diagnosis given by doctor	The first doctor consulted (name, address & telephone)
Is the condition due to an accident? ☐ No. ☐ Yes, details below:	
Accident Date MM DD YYYY	Time (am / pm) Place
Accident Details	

Consultation Details

	Name, Address & Telephone	Consultation Dates	Disease / Condition
a) Insured's regular doctor			
b) All other doctors consulted for this illness/injury; or similar condition in the past			

Registered and Corporate Office : Tata AIA Life Insurance Company Ltd. (IRDA Regn. No. 110),14th Floor, Tower A, Peninsula Business Park, Senapati Bapat Marg, Lower Parel, Mumbai 400013. CIN: U66010MH2000PLC128403.
CLP/P4.9/4.T39 (I)

Version 1

c) Doctor who referred Insured to hospital			

Please give details of any other illness Insured have suffered from in the past.

Disease/Condition	Consultation Dates	Doctor consulted (Name, Address & Telephone No.)

Hospitalization Details

Details of hospital confinement for the injury/illness.

Name of Hospital	Address	Date of consultation(s)	Date & time of admission	Date & time of discharge

Any surgical procedure(s) done during hospitalization?

☐ No ☐ Yes, details:

Information of Claimant (if other than the Life Insured)

[Note:- Claimant name should be written in full as the same will appear on the cheque]

Name in Full	ID No.	ID Type	Age
Sex: Male ☐ Female ☐	Address		
Telephone No.	Relationship with the Insured		
In what title are you submitting this claim?	**Bank Account no.**		

DECLARATION AND AUTHORIZATION

I/We hereby declare that the information given on this accident/hospitalization claim application form is true and complete.
/We hereby make claim to Tata AIA by submitting this accident/hospitalization claim application form and agree that the written statements of all the physicians who attended or treated the Insured and all other proofs and supporting documents associated with this accident/hospitalization claim application form shall constitute and are hereby made part of this accident/hospitalization claim application form. I/We further agree that the furnishing of this accident/hospitalization claim application form, or of any other forms supplemental hereto by the Company, shall not be deemed an admission of an existence of any assurance in force on the life in question, nor an admission of liabilities or a waiver of any of its rights of defenses.

I/We hereby declare and agree that any personal information collected or held by the Company (whether contained in this application or otherwise obtained) is provided and may be held, used, and disclosed by the Company to individuals/organizations associated with the Company or any selected third party (within or outside of India, including reinsurance and claims investigation companies and industry associations/federations) for the purposes of processing this application and providing subsequent services for this and other financial products and services, direct marketing, and data matching, and to communicate with me/us for such purposes.

I/We hereby irrevocably authorize: (i) any organization, institution, or individual that has any record or knowledge of my/the Insured's health and medical history or any treatment or advice and that has been or may hereafter be consulted, other personal information or details of related accident/injury to disclose to the Company such information; (ii) the Company and its approved medical examiners and laboratories to perform medical assessment and tests to evaluate Insured's health condition, or to perform any autopsy as appropriate.

This authorization shall bind my/the Insured's successors and assigns and remain valid notwithstanding my/the Insured's heath or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.

Witness Signature: _____

Date: _____

Name of Witness: _____
(in block letters, family name first)

Life Insured Signature: _____

Date: _____

Policyowner/Claimant
(If other than life Insured)
Signature: _____

Name: _____
(in block letters, family name first)

Date: _____

Note: - Witness should be a Notary/ Gazetted officer /Gram Panchayat Pradhan/Gram Panchayat member/Doctor/Lawyer/School headmaster/Ward councilor/Block Development Officer/NGO/ Bank Manager/BOI/BOE/CSO/Zone claims person/Branch claims person/ZCSM/ SEM or a person of local standing.

CLM/P4.9/4.T3 (II) - 29May2003

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